IN THE SUPREME COURT

Appeal from the Michigan Court of Appeals
(Before Fitzgerald, P.J., Neff, J.J., and White, J.J.)

MICHIGAN CHIROPRACTIC COUNCIL and the MICHIGAN CHIROPRACTIC SOCIETY,

Petitioners/Appellees,

v

COMMISSIONER OF FINANCIAL AND INSURANCE SERVICES,

Respondent,

and

FARMERS INSURANCE EXCHANGE and MID-CENTURY INSURANCE COMPANY,

Intervening Respondents/Appellants.
_____/

Supreme Court Nos. 126530 and 126531

Court of Appeals Nos. 241870 and 241874

Ingham County Cir. Ct. No. 01-93481-AA

BRIEF ON APPEAL – APPELLANTS

THE APPEAL INVOLVES A RULING THAT A PROVISION OF THE CONSTITUTION, A STATUTE, RULE OR REGULATION, OR OTHER STATE GOVERNMENTAL ACTION IS INVALID

ORAL ARGUMENT REQUESTED

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STATEMENT OF JURISDICTION

Farmers Insurance Exchange and Mid-Century Insurance Company (collectively, "Farmers") appeal under Michigan Court Rule 7.301(A)(2) the decision and order of the Court of Appeals dated June 1, 2004, *see Michigan Chiropractic Council v Comm'r of the Office of Fin and Ins Servs*, 262 Mich App 228; 685 NW2d 428 (2004), which affirmed the May 22, 2002 decision of the Ingham County Circuit Court[1] (*see* Cir Ct Op (App at 146a-55a).) The Circuit Court issued the May 22 Order as its final judgment on appeal from two Administrative Orders issued by the Commissioner of Financial and Insurance Services (the "Commissioner") (*see* Admin Orders, Jan 23 and March 21, 2001 (App at 63a-81a).) The Administrative Orders denied a petition filed by Appellees, Michigan Chiropractic Council and Michigan Chiropractic Society ("MCC/MCS") (*see* Pet's Req for Adm Proc, Aug 10, 2000 (App at 3a-14a)), challenging the legality of a no-fault insurance product offered by Farmers and asking the Commissioner to initiate contested case proceedings.

Farmers asks this Court to reverse the judgment of the Court of Appeals and to reinstate the Administrative Orders of the Commissioner.

[1] The Circuit Court's May 22, 2002 Order modified in part and restated and incorporated in part an earlier Opinion and Order of the Circuit Court dated April 30, 2002 (Cir Ct Op (App at 135a-41a).)

QUESTIONS PRESENTED FOR REVIEW

1. Can an insurer, as an endorsement to a standard no-fault insurance policy, offer to provide no-fault personal injury protection benefits ("PIP benefits") through a system of managed care, such as a health-maintenance organization ("HMO") or a preferred provider organization ("PPO"), in exchange for reduced insurance premiums, where the insured's election to purchase the endorsement is entirely voluntary?

The Insurance Commissioner said: **Yes**

The Circuit Court said: **No**

The Court of Appeals said: **No**

Appellant Farmers says: **Yes**

2. Did the Court of Appeals err in finding that Farmers' managed care endorsement is potentially "misleading" and "illusory" to insureds?

Appellant Farmers says: **Yes**

3. Do MCC/MCS have standing to bring their petition, in light of some number of their members having participated as chiropractors in Farmers' managed care program, or any other reason affecting standing, and do MCC/MCS have standing as to all or only some of the counts in their petition?

The Insurance Commissioner said: **Did not address**

The Circuit Court said: **Did not address**

The Court of Appeals said: **Did not address**

Appellant Farmers says: **No**

4. Did the Circuit Court apply the correct standard of review to the Commissioner's decision denying MCC/MCSs' petition for contested case proceedings?

The Court of Appeals said: **Yes**

Appellant Farmers says: **No**

INTRODUCTION

This case involves a challenge by MCC/MCS to a decision by the Commissioner to approve a no-fault insurance endorsement offered by Farmers to Michigan insureds. The endorsement allows insureds to reduce their no-fault insurance premiums by voluntarily agreeing to receive PIP benefits through a system of managed care, such as an HMO or a PPO. The Court of Appeals held the No-Fault Act bars Farmers from offering the endorsement because it limits an insured's available choices for medical services, and because the endorsement is allegedly "misleading" and "illusory" with regard to the savings to be achieved by insureds who select it.

The Court of Appeals erred for three reasons. The first two are threshold issues requiring immediate reversal. First, the court wrongly assumed MCC/MCS have standing to assert their claims. MCC/MCS do not have standing where they have asserted no injury to their own members, where their purposes as chiropractic organizations are not germane to suing on behalf of no-fault insureds, and where many of their members, having joined Farmers' network of physicians, are actively benefiting from the endorsement at the same time MCC/MCS tries to invalidate it.

Second, the Court of Appeals improperly affirmed the trial court's decision applying the wrong standard of review. Under well-settled case law, the trial court should have limited its review to whether the Commissioner's actions were "authorized by law," that is, whether the Commissioner had the power and authority to act as he did. Instead, it considered *de novo* the merits of the Commissioner's decision to deny MCC/MCSs' request for commencement of administrative proceedings. The Court of Appeals perpetuated this error by affirming the trial court's ruling on the merits.

Finally, even though it should not have reached the substantive issues, the Court of Appeals' ruling is wrong on the merits. This Court held in *Tousignant* v *Allstate Ins Co*, 444 Mich 301, 310; 506 NW2d 844 (1993), that the fundamental feature of a managed care system – a limited choice of physicians and facilities – does not offend the No-Fault Act as long as it is voluntarily chosen by the insured, as it is here. Moreover, as the Commissioner rightly concluded, as long as the insurer provides and pays for all reasonably necessary medical services, there is no reason why a system of managed care for PIP benefits cannot be offered to insureds through a voluntary endorsement to a standard no-fault insurance policy, nor is there anything "misleading" or "illusory" about doing so. With coordinated coverage under the No-Fault Act, thousands of Michigan residents already choose to receive medical care for automobile injuries through HMOs and PPOs in exchange for reduced no-fault premiums. If the Act bars managed care for automobile injuries, thousands of existing no-fault insurance policies are illegal, and a massive rewriting of no-fault insurance will be required.

For all of these reasons, Farmers respectfully requests that the Court of Appeals' decision be reversed and the Commissioner's ruling denying MCC/MCSs' petition for contested case proceedings be reinstated.

STATEMENT OF FACTS

I. FARMERS AND THE PREFERRED PROVIDER ORGANIZATION OPTION ENDORSEMENT.

Farmers writes no-fault insurance in the State of Michigan. It provides Michigan residents with three no-fault insurance options. First, an insured may elect a standard no-fault policy and pay the standard PIP premiums. (*See* Pet's Req for Admin Proc, Aug 10, 2000, Ex A (App at 12a).) Under this option, which is available to all Michigan residents, an insured does not agree to any contractual limitation on the choice of physicians or medical facilities and, for

automobile injuries, Farmers pays a provider of reasonably necessary medical services a reasonable fee. (*Id.*)

Second, an insured may elect to coordinate no-fault insurance with the insured's health insurance, making the health insurer the primary source of payment. (*See* Pet's Req for Admin Proc, Aug 10, 2000, Ex A (App at 12a).) This option is available regardless of the nature of the insured's health insurance, and no-fault insurance may be coordinated with standard health insurance, HMOs, or PPOs. Under coordinated coverage, an insured's medical expenses for automobile injuries are paid directly by the health insurer, HMO, or PPO, to the extent of the provided coverage. In exchange for electing coordinated coverage, Farmers grants the insured a 25 percent reduction in PIP premiums. (*Id.*) This option is available only to insureds who have general health insurance.

Finally, an insured may elect a Preferred Provider Organization Option Endorsement (the "PPO Option"). (*See* Pet's Req for Admin Proc, Aug 10, 2000, Ex A (App at 12a).) The PPO Option parallels coordinated coverage where the primary insurer is an HMO or PPO. With the PPO Option, however, the opportunity to receive medical treatment for automobile injuries through managed care is made available on a voluntary basis to all Michigan residents, rather than only to those residents having an HMO or PPO as their primary health insurance.

Under the PPO Option, the insured agrees to receive treatment for automobile injuries from Preferred Providers of Michigan ("PPOM"), a network of physicians, hospitals, and other health care providers, and Farmers pays PIP benefits to the PPOM providers at rates contractually agreed to by PPOM and Farmers. (*See* Pet's Req for Admin Proc, Aug 10, 2000, Ex's A and B (App at 12a-14a).) In exchange for agreeing to use PPOM, Farmers grants the

insured a 40 percent reduction in PIP premiums. (*Id.*) An insured voluntarily electing the PPO Option may use non-PPOM medical providers, but in such event, PIP benefits are subject to a $500 deductible.[2] (*Id.*)

The PPO Option is a relatively new insurance product, designed to give insureds a wider range of choices. It was approved for use in Michigan by the Commissioner on July 1, 2000.[3] Farmers has been offering the PPO Option to insureds since that date and, as of April 2002, Farmers had 22,593 PPO Option policies in place. (Aff of Rubin Snowden ¶7, filed with the Circuit Court (App at 142a-45a).) The PPO Option presents every Michigan resident with the opportunity to select voluntary managed care for PIP benefits in exchange for a substantial reduction in PIP premiums. Michigan residents can tailor their insurance to fit their economic and other needs by choosing among standard PIP benefits, coordinated PIP benefits, or managed care PIP benefits under the PPO Option.

PPOM offers a full of menu of medical services and provides insureds with a wide choice of medical providers and facilities. More than 300 hospitals and 30,000 physicians are members of PPOM. The network includes providers of medical, chiropractic, optometric, pediatric, hospital, nursing, x-ray, dental, surgical, ambulance, and prosthetic services. (*See* Response by Farmers, Sept 25, 2000, Ex 2 (App at 44a).) Over 1,200 Michigan chiropractors and chiropractic clinics are members of the network, **including many members of MCC and**

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[2] In this regard, the PPO Option is less restrictive than coordinated coverage. Where no-fault insurance is coordinated with an HMO or PPO, and the insured utilizes a medical provider outside the managed care system for medical services available from the HMO or PPO, the no-fault insurer is not required to cover **any** portion of the provider's fee. *See Tousignant, supra* at 307 ("We conclude, however, that the legislative policy that led to the enactment of § 3109a requires an insured who chooses to coordinate no-fault and health coverage to obtain payment and services from the health insurer to the extent of the health coverage available from the health insurer.").

[3] Under MCL 500.2236(1), an insurance policy cannot be sold in Michigan until a copy of the policy has been filed with and approved by the Commissioner as conforming with the requirements of the Act and not inconsistent with law. Failure of the Commissioner to act on a policy within 30 days of filing constitutes approval of the policy. *See* MCL 500.2236(1). The PPO Option was approved through this process effective July 1, 2000.

MCS. (*See* Aff of Lynne Wharton, filed with the Court of Appeals (App at 206a-08a)); *see also* www.chiromi.com; www.michiganchiropractic.org.)

II. MCC/MCS AND THE REQUEST FOR COMMENCEMENT OF ADMINISTRATIVE PROCEEDINGS.

MCC/MCS are voluntary associations of chiropractors. They exist to promote the interests of chiropractors and chiropractic care. MCS describes its mission as being "to perpetuate the chiropractic profession as a separate and distinct branch of the healing arts." http://chiromi.com/mission_statement.htm. MCC, which changed its name to the Michigan Chiropractic Association in 2002, has a similar function: "Our mission: 'To promote and protect the principles of chiropractic as a separate and distinct healing art, through service and education to the chiropractic profession, members and the public.'" www.michiganchiropractic.org. MCC/MCS do not exist, or claim to exist, to promote the interests of no-fault insureds.

On August 10, 2000, MCC/MCS filed with the Commissioner a Request for Issuance of Notice of Hearing and Commencement of Administrative Proceedings (the "Request"). (Pet's Req for Admin Proc, Aug 10, 2000 (App at 3a-14a).) The Request included two counts relevant to this appeal: (1) the PPO Option violates the rights of insureds by providing for PIP benefits to be paid through a system of managed care, allegedly in conflict with § 3107 and "the general purposes of the No-Fault Act," (*see id.* at Count 1, ¶¶ 9, 17, 18 (App at 5a, 7a, 8a)); and (2) the PPO Option violates the rights of medical care providers by, among other things, "forc[ing]" providers to join PPOM and accept rates less than their customary fees in violation of § 3157, (*see id.* at Count 2, ¶ 24 (App at 9a).)[4]

[4] MCC/MCS asserted two additional counts, neither of which is relevant here. First, the original Request alleged in Count 3 that the PPO Option violates the rights of insureds by subjecting them to an alleged $500 "penalty" for seeking care outside the PPOM network. (*See* Pet's Req for Admin Proc, Aug 10, 2000, Count 3, ¶¶ 26-28 (App at 10a).) Second, on November 22, 2000, MCC/MCS filed a First Amended Petition for Issuance of Notice of Hearing and Commencement of Administrative Proceedings ("Amended Petition"). (*See* Pet's First Amended Pet for Admin

Farmers filed its response to the original Request on September 25, 2000. (Response by Farmers, Sept 25, 2000 (App at 15a-46a).) After requesting and receiving additional information from both parties, the Commissioner issued an Administrative Order denying the Request on January 23, 2001. (Admin Order, Jan 23, 2001 (App at 63a-78a).) The Commissioner ruled that:

1. Because adequate care can be provided through a network of competent providers covering the full range of medical needs, the PPO Option is not in conflict with § 3107 of the Act, which requires no-fault insurance to cover all reasonably necessary medical services. (*Id.* at 6-7 (App at 68a-69a).)

2. The successful referendum on 1993 PA 143 is irrelevant to the legality of the PPO Option because 1993 PA 143 allowed no-fault insurers to unilaterally impose managed care on insureds, while the PPO Option is entirely voluntary with the insured. (*Id.* at 8-9 (App at 70a-71a).)

3. Nothing in the Act prohibits an insured from voluntarily agreeing to limit the insured's choice of physicians and facilities in exchange for receiving reduced no-fault insurance premiums. (*Id.* at 10-11 (App at 72a-73a).)

4. Nothing in the Act prohibits medical care providers from voluntarily

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Proc, Nov 22, 2000 (App at 47a-62a).) The Amended Petition included the same Counts 1-3 as the original Request, but also included Count 4, which raised an unrelated issue concerning Farmers' actions under its coordinated no-fault insurance policies. (*See id.* at Count 4 (App at 54a-57a).) The Commissioner issued its Administrative Orders denying Counts 1-3 on January 23, 2001, and denying Count 4 on March 21, 2001. (Admin Orders, Jan 23 and March 21, 2001 (App at 63a-81a).) MCC/MCS filed a Petition for Review in the Circuit Court on April 18, 2001. (Pet's Petition for Review, April 18, 2001 (App at 83a-98a).) The Petition for Review includes three counts, labeled 1-3. These counts repeat the claims from Counts 1, 2, and 4 from MCC/MCSs' original Request and Amended Petition. (*See* Pet's Petition for Review, at Counts 1, 2, and 3 (App at 89a-98a).) MCC/MCS did not request review of the Commissioner's ruling regarding Count 3. (*See id.*) As a result, the original Count 4 became the new Count 3 in the Petition for Review. (*See id.* ¶¶ 49-62 (App at 95a-97a).) This new Count 3 was then rendered moot when the Court of Appeals ruled on the issue in *Sprague v Farmers Ins Exchange*, 251 Mich App 260; 650 NW2d 374 (2002). Therefore, Counts 3 and 4 of the Amended Petition have both been disposed of by other means and are no longer at issue. This appeal involves only Counts 1 and 2 as set forth in MCC/MCSs' original Request, its Amended Petition, and its Petition for Review in the Circuit Court.

agreeing to provide care at less than their customary fees in exchange for participation in a network of providers that may give them access to additional patients. (*Id.*)

On April 18, 2001, MCC/MCS appealed the Administrative Order by filing a Petition for Review ("Petition for Review") with the Ingham County Circuit Court. (Pet's Petition for Review (App at 83a-134a).) After full briefing by the parties and oral argument, the Circuit Court issued an Order and Opinion reversing the Commissioner's Administrative Order. (Cir Ct Op (App at 146a-55a).) The Circuit Court ruled that the PPO Option conflicts with the Act because: (1) when an insured voluntarily elects the PPO Option, a provider must be a member of PPOM to receive payment under the insured's no-fault insurance, *i.e.*, the Act prohibits an insured from voluntarily choosing to limit the physicians from whom the insured will seek medical services in the event of an automobile accident, (*see id.* at 6 (App at 154a)); and (2) when a provider voluntarily chooses to join PPOM, the provider agrees to accept less than the provider's customary fees, *i.e.*, the Act prohibits medical care providers from voluntarily agreeing to accept less than customary fees, (*id.*).

Farmers filed for and was granted leave to appeal to the Court of Appeals. The Court of Appeals stayed all proceedings and, in an opinion dated June 1, 2004, ruled against Farmers and the Commissioner on two grounds. *See Michigan Chiropractic Council, supra.* First, the court held that the PPO Option violates the No-Fault Act by limiting an insured's choice of medical service providers.[5] *See id.* at 243-247. It held that such a system "cannot emanate from the innovations of insurance companies or the courts, but only from the Legislature itself." *Id.* at 246. Second, a two-member majority of the Court held that the PPO

[5] The Court opined: "General no-fault benefits under subsection 3107(1)(a) offer a range of choice. Managed care, under a PPO plan, offers only limited choice. The substitution of a PPO plan for no-fault general medical benefits is therefore not in keeping with the no-fault act." *See id.* at 243.

Option violates the No-Fault Act because it could potentially mislead consumers about the potential savings to be achieved by selecting the Option. *See id.* at 240-41. The latter issue had not been addressed by the Circuit Court, and there was no administrative or trial court record on which the Court of Appeals could base such a finding. The issue also had not been briefed or argued by the parties on appeal. In issuing its ruling, the Court of Appeals reached the merits of MCC/MCSs' claims without discussing standing.

III. THIS COURT'S DECISION IN *ADVOCACY ORG* MOOTS COUNT 2 OF MCC/MCSs' REQUEST, AMENDED PETITION, AND PETITION FOR REVIEW.

As discussed above, MCC/MCS alleged in Count 2 of their Request, Amended Petition, and Petition for Review that the PPO Option violates the rights of medical providers under § 3157 of the No-Fault Act. (*See* Pet's Req for Admin Proc, Aug 10, 2000, Count 2, ¶¶ 20-25 (App at 8a-10a).) According to Count 2, this provision creates an entitlement for care providers to be reimbursed their "customary" fees for services provided under the Act, (*see id.* ¶ 24 (App at 9a)), and the PPO Option violates this alleged entitlement by "forcing" providers to join PPOM and thus receive less than their customary fees, (*see id.*) The Court of Appeals rightly rejected this claim, *see Michigan Chiropractic Council, supra* at 246 n 12, pointing to the recent decision in *Advocacy Org for Patients & Providers* v *Auto Club Ins Ass'n*, 257 Mich App 365, 375-76; 670 NW2d 569 (2003), which held that § 3157 merely places a cap on the amount care providers can charge for their services, and does not create an entitlement for reimbursement of customary fees.

This Court recently affirmed *Advocacy Org* on all grounds. *See Advocacy Org for Patients & Providers* v *Auto Club Ins Ass'n*, 472 Mich 91, 95; 693 NW2d 358 (2005) ("Because we agree with the Court of Appeals resolution of this issue, and the others presented to it, we

affirm."). Therefore, for purposes of this appeal, only Count 1 of MCC/MCSs' Request, Amended Petition, and Petition for Review remains alive.

STANDARD OF REVIEW

The correct standard of review for the Commissioner's denial of MCC/MCSs' request for contested case proceedings is the "authorized by law" standard. *See Brandon School Dist* v *Michigan Ed Special Servs Ass'n, et al.*, 191 Mich App 257; 477 NW2d 138 (1991). In *Brandon*, the court explained the standard of review as follows: "[w]here no hearing is required, it is not proper for the circuit court or this Court to review the evidentiary support of an administrative agency's determination. Judicial review is **not *de novo*** and is limited in scope to a determination whether the action of the agency was authorized by law." *Id.* at 263 (emphasis added).

ARGUMENT

I. MCC/MCS DO NOT HAVE STANDING TO ASSERT THEIR CLAIMS.

The Court of Appeals incorrectly assumed that MCC/MCS have standing to assert their claims that the PPO Option violates the No-Fault Act. "The doctrine of standing is a constitutional principle that prevents courts of law from undertaking tasks assigned to the political branches." *Lee* v *Macomb County Bd of Comm'rs*, 464 Mich 726, 736; 629 NW2d 900 (2001) (quoting *Lewis* v *Casey*, 518 US 343, 349; 111 S Ct 2174; 135 L Ed 606 (1996)). In general terms, "[s]tanding requires a demonstration that the plaintiff's substantial interest will be detrimentally affected in a manner different from the citizenry at large." *Id.* at 738-39. In *Lee*, this Court adopted the following three-part test as the "irreducible constitutional minimum of standing" under Michigan law:

> First, the plaintiff must have suffered an injury in fact – an invasion of a legally protected interest which is (a) concrete and particularized, and (b) actual or

> imminent, not conjectural or hypothetical. Second, there must be a causal connection between the injury complained of – the injury has to be fairly traceable to the challenged action of the defendant, and not . . . the result of the independent action of some third party not before the court. Third, it must be likely, as opposed to merely speculative, that the injury will be redressed by a favorable decision.

Id. at 739-40 (following *Lujan* v *Defenders of Wildlife*, 504 US 555; 112 S Ct 2130; 119 L Ed 351 (1992)). As plaintiff, MCC/MCS bears the burden of establishing these elements. *See id.* at 740 (citation omitted).

This Court applies the general standing principles announced in *Lee* not only to individual plaintiffs, but also to membership organizations, like MCC/MCS, who claim the right to sue on behalf of their members. *See, e.g., Associated Builders & Contractors* v *Wilbur*, 472 Mich 117, 126-127 & n 16; 693 NW2d 374 (2005) (standing for membership associations "is governed by the test adopted in *Lee*"); *Nat'l Wildlife Fed'n* v *Cleveland Cliffs Iron Co*, 471 Mich 608, 628-29; 684 NW2d 800 (2004) (same). Thus, "[n]onprofit organizations . . . have standing to bring suit in the interest of their members **where such members would have standing as individual plaintiffs**." *Cleveland Cliffs, supra* at 629 (citations omitted) (emphasis added). The association must demonstrate, among other things, that its members have suffered an actual or imminent injury. *See id.*; *accord Trout Unlimited* v *White Cloud,* 195 Mich App 343, 348-49; 489 NW2d 188 (1992) (members of an association must "themselves have a sufficient stake or have sufficiently adverse and real interests in the matter being litigated.").

In addition to the "irreducible constitutional minimum" announced in *Lee*, the United States Supreme Court has articulated two additional factors for deciding whether an association has standing to sue on behalf of its members. *See Hunt* v *Washington State Apple Advertising Comm'n,* 432 US 333, 343; 97 S Ct 2434; 53 L Ed 383 (1977). The association must show that "the interests it seeks to protect are germane to the organization's purpose," and

"neither the claim asserted nor the relief requested requires the participation of individual members in the lawsuit." *Id.* at 343. While this Court has never adopted these additional factors, they are consistent with this Court's recent jurisprudence applying federal standing principles. *See Lee, supra* at 737 ("In Michigan, standing has developed on a track parallel to the federal doctrine . . . ."). The factors are also consistent with this Court's desire to honor separation of powers principles and to ensure that claims are asserted only by those with a sufficient stake in the controversy. *See id.* at 735-36; *Detroit Fire Fighters Ass'n v City of Detroit,* 449 Mich 629, 633; 537 NW2d 436 (1995).

Applying these standards here, MCC/MCS do not have standing.

A. MCC/MCS Do Not Have Standing Because the Only Allegation of Injury is to Michigan Insureds and Not to MCC/MCSs' Members.

MCC/MCS allege in Count 1 (the only Count left in this appeal) of their original Request (which allegations are repeated in Count 1 of their Amended Petition and Petition for Review) that the PPO Option violates the rights of **insureds** under the No-Fault Act. (Pet's Req for Admin Proc, Aug 10, 2000, Count 1, at 3-6 (App at 5a-8a).) Count 1 of the Request states in relevant part as follows: "COUNT I . . . VIOLATES RIGHTS OF INSUREDS . . . 19. Farmers, by insisting upon a managed care program which has been rejected at the polls, has sought to improperly thrust a statutory scheme on **insureds** which violates their rights under the No-Fault Act . . . ." (*Id.* at 3, 6 (App at 5a, 8a) (underlining in original; bold added).) There is no allegation in Count 1 of the Request – let alone any evidence produced by MCC/MCS – of any injury to the members of MCC or MCS. (*See id.* at 3-6 (App at 5a-8a.).)

MCC/MCS simply do not have standing under these circumstances. As this Court has explained, "[t]raditionally, a private citizen has no standing to vindicate a public wrong or enforce a public right where he is not hurt in any manner differently than the citizenry

at large." *Detroit Fire Fighters*, *supra* at 634 (citation omitted). In *Detroit Fire Fighters*, the plaintiff-association sued the City of Detroit, alleging an increased risk of injury, emotional distress, loss of morale, and other damages as a result of the city's impoundment of certain budgeted monies. *See id.* at 635. The Court held these allegations were not sufficient to confer standing on the association: "These general allegations of harm, coupled with their membership in a trade organization, cause plaintiffs to believe they are entitled to standing . . . . Plaintiff's belief is misplaced. . . . **We find that the harm claimed by plaintiffs is no different than that to be suffered by the general public.**" *Id.* at 635-38 (emphasis added); *accord Reed* v *Reed*, 265 Mich App 131, 159; 693 NW2d 825 (2005) (defendant lacked standing to assert that trial court's actions had deprived others of due process); *Fieger* v *Comm'r of Ins*, 174 Mich App 467, 471; 437 NW2d 271 (1988) ("A plaintiff must assert his own legal rights and interests and cannot rest his claim to relief on the legal rights or interests of third parties."); *Human Rights Party* v *Michigan Corrections Comm'n*, 76 Mich App 204; 256 NW2d 439 (1978) (political party does not have standing to assert constitutional rights of prison inmates); *Saginaw Fire Fighters Ass'n* v *Police & Fire Dep't Civil Serv Comm'n*, 71 Mich App 240, 247; 247 NW2d 365 (1976) (firefighters' union lacked standing because it failed to demonstrate any injury to its current membership).

The same is true here. MCC/MCS cannot assert injuries on behalf of third parties, *i.e.*, no-fault insureds. They must establish injury to the rights or interests of their own members. Because there is no evidence of injury to MCC/MCSs' members, MCC/MCS do not have standing to bring Count 1 of their Request, Amended Petition, and Petition for Review, the only count remaining in this case. To hold otherwise would be to permit MCC/MCS to bring

suit based on alleged injuries to third parties, and injuries no different than those experienced by the general public.

B. Count 1 of the Request, Amended Petition, and Petition for Review is Not Germane to MCC/MCSs' Organizational Purposes.

Assuming *arguendo* that MCC/MCS could establish injury to their members, they still would not have standing to assert Count 1 of their Request, Amended Petition, and Petition for Review. As discussed above, the U.S. Supreme Court has held an association has standing to sue on behalf of its members only where "the interests it seeks to protect are germane to the organization's purpose." *Hunt, supra* at 333. The requirement for germaneness "grows out of the case or controversy requirement" and assures that the association, "through its goals and purposes as an association," has a "vested interest in the outcome of the litigation. . . ." *Mountain States Legal Found'n* v *Dole*, 655 F Supp 1424, 1429 (D Utah 1987); *see also United Food & Comm'l Workers Union Local 751 v Brown Group*, 517 US 544, 555-56; 116 S Ct 1529; 134 L Ed 758 (1996) (the germaneness requirement "raises an assurance that the association's litigators will themselves have a stake in the resolution of the dispute, and thus be in a position to serve as the defendant's natural adversary.").

Courts routinely strike the claims of associations who fail to demonstrate the required nexus between their claims and the associations' purpose. For example, in *Central South Dakota Cooperative Grazing District* v *Sec'y of Interior*, 266 F3d 889 (CA 8, 2001), the court held that the plaintiff-association failed to demonstrate germaneness: "The Grazing District is a corporation of individual ranchers organized to cooperatively operate and manage grazing lands. We find no indication that the Grazing District has any interest in protecting the wildlife habitat within the Grasslands," *id.* at 897; *accord McKinney* v *United States Dept of*

Treasury, 799 F2d 1544 (Fed Cir 1986) (same); *Wyoming Timber Indus Ass'n* v *United States Forest Serv*, 80 F Supp 2d 1245 (D Wyo 2000) (same).

The same is true in this case. According to their own websites, MCC/MCS are associations of chiropractors who describe their missions as being to promote their profession as a "separate and distinct branch" of the healing arts. (*See* Statement of Facts, *supra* at 5.) Such a purpose has nothing whatsoever to do with asserting claims on behalf of insureds under the No-Fault Act. Therefore, the associations' interests simply are not germane to the claims asserted in Count 1 of the Request, Amended Petition, and Petition for Review.

Of course, all of this merely highlights the real reason MCC/MCS filed this suit to begin with. Although they allege the PPO Option is bad for insureds, their real interest is to advance the bottom lines of their members. They understand that any savings realized by insureds from selecting the Option will be paid for by care providers, including chiropractors, who agree to perform services at network rates. And they understand that care providers who join PPOM, and thus charge less than their ordinary rates, will have a competitive advantage over those who do not. Thus, while MCC/MCS claim to be looking out for the interests of insureds, what they are really doing is trying to take **away** the right of insureds to save money on their no-fault premiums. In doing so, they threaten to take away an option that thousands of Michigan insureds have evaluated, found to be in their best interests, and voluntarily selected.

C. MCC/MCS Do Not Have Standing Since Many of Their Members Have Joined PPOM and Are Benefiting From It.

The final prong of the associational standing test articulated by the U.S. Supreme Court requires the plaintiff to show that "neither the claim asserted nor the relief requested requires the participation of [the association's] individual members in the lawsuit." *Hunt*, *supra* at 343. This means an association may not have standing if the suit would create conflicts of

interest among its members. *See, e.g., Maryland Highways Contractors Ass'n v Maryland,* 933 F2d 1246, 1252-53 (CA 4, 1991). In *Maryland Highways*, an association of contractors brought suit to challenge Maryland's minority business statute. Because a number of members of the association were minority businesses that actually benefited from the statute, while other non-minority members would benefit if the statute was declared unconstitutional, the Fourth Circuit concluded there were conflicts of interest such that individual members would have to join the suit in order to protect their interests. *See id.* The court held the association did not have standing unless the members with conflicting interests joined the suit as individuals to protect their interests. *See id.*; *accord Associated Gen Contractors of North Dakota v Otter Tail Power Co*, 611 F2d 684, 691 (CA 8, 1979) ("[The members'] status and interests are too diverse and the possibilities of conflicts too obvious to make the association an appropriate vehicle to litigate the claims of its members. . . . **[S]ome stand to benefit from working on the project under the Agreement and still others will be hurt by not being able to do so.**"); *Mountain States, supra* at 1431 ("It is entirely conceivable in this case . . . that many members of [the association] would oppose this litigation either on ideological grounds or even because they are the beneficiaries of the Act's affirmative action provisions.").

In this case, MCC/MCS cannot meet this requirement. As discussed above, many members of MCC/MCS have joined PPOM as providers of chiropractic services, (*see* Statement of Facts, *supra* at 5), and are thus **benefiting** from the Option at the same time the associations are pursuing this suit to have it invalidated. This means individual members would have to join the suit in order to assure that their interests are being properly advocated. Therefore, under the final prong of the *Hunt* test, MCC/MCS do not have standing to bring Count 1 of their Request, Amended Petition, and Petition for Review.

II. THE CIRCUIT COURT APPLIED THE WRONG STANDARD OF REVIEW TO THE COMMISSIONER'S DECISION NOT TO INSTITUTE CONTESTED CASE PROCEEDINGS.

As discussed above, the proper standard of review is whether the Commissioner's actions are "authorized by law." (*See* Standard of Review, *supra* at 12-13 (quoting *Brandon*, *supra*).) Under this standard of review, the agency's decision must be affirmed "unless it is in violation of statute, in excess of the statutory authority or jurisdiction of the agency, made upon unlawful procedures resulting in material prejudice, or is arbitrary and capricious." *Brandon*, *supra* at 263. The purpose of this restricted standard is to insulate the agency's judgments, which are made pursuant to statutory authorization, from second-guessing by the courts.

In this case, the Circuit Court correctly identified the standard of review in its decision. (Cir Ct Op at 2-3 (App at 150a-51a) (*citing Northwestern Nat'l Cas Co v Ins Comm'r*, 231 Mich App 483, 490; 586 NW2d 563 (1998).) The court, however, did not actually abide by the standard of review in issuing its opinion. (*See id.* at 6 (App at 154a).) Rather than limiting its review to the question of whether the Commissioner's decision not to institute contested case proceedings was authorized by law, the court reviewed the decision *de novo* and concluded that the PPO Option violated the No-Fault Act:

> [T]he Court is persuaded by Petitioners' argument that Farmers' Option illegally adds an additional requirement that health care providers must be members of Farmers' exclusive Preferred Provider network. The Court agrees with Petitioners that this requisite conflicts with the Act's requirement that health care providers be reimbursed when providing treatment for a covered injury. Moreover, Petitioners have convinced the Court that chiropractors who wish to participate in the no-fault system for Farmers' insureds are forced to accept a fee which is less than the customary and reasonable fee required by the Act.

(*Id.* at 6 (App at 154a).)

This *de novo* review by the Circuit Court violates the standard of review. Under MCL 500.2028[6], 500.2029[7], 500.2043[8] and other applicable statutes, the Commissioner's decision whether or not to institute contested case proceedings is discretionary. *See Brandon, supra* at 264. In *Brandon,* the Insurance Commissioner denied the petitioners' request for a contested case hearing regarding whether the defendants had violated the Insurance Code, determining that there was no probable cause of a violation. On appeal, the petitioners argued that the Commissioner's exercise of this discretion was arbitrary and capricious because they disagreed with the Commissioner's judgment not to institute case proceedings. *See id.* at 264. This, of course, is precisely what MCC/MCS argue in this case – that there was probable cause

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[6] MCL 500.2028 states that

> Upon probable cause, the commissioner shall have power to examine and investigate into the affairs of a person engaged in the business of insurance in this state to determine whether the person has been or is engaged in any unfair method of competition or in any unfair or deceptive act or practice prohibited by sections 2001 to 2050.

[7] MCL 500.2029 provides that

> When the commissioner has probable cause to believe that a person engaged in the business of insurance has been engaged or is engaging in this state in an unfair method of competition, or an unfair or deceptive act or practice in the conduct of his business, as prohibited by sections 2001 to 2050, and that a hearing by the commissioner in respect thereto would be in the interest of the public, he shall first give notice in writing, pursuant to Act No. 306 of the Public Acts of 1969, as amended, being sections 24.201 to 24.315 of the Michigan Compiled Laws, to the person involved, setting forth the general nature of the complaint against him and the proceedings contemplated pursuant to sections 2001 to 2050. Before the issuance of a notice of hearing, the staff of the bureau of insurance responsible for the matters which would be at issue in the hearing shall give the person an opportunity to confer and discuss the possible complaint and proceedings in person with the commissioner or his representative and the matter may be disposed of summarily upon agreement of the parties.

[8] MCL 500.2043 provides that

> Whenever the commissioner has probable cause to believe that any person engaged in the business of insurance is engaging in this state in any method of competition or in any act or practice in the conduct of such business which is not defined in sections 2005 through 2025, that such method of competition is unfair or that such act or practice is unfair or deceptive and that a proceeding by him in respect thereto would be in the interest of the public, the commissioner may issue and serve upon such person a statement of the charges in that respect and a notice of a hearing thereon to be held at a time and place fixed in the notice, which shall not be less than 15 days after the date of the service thereof. Each such hearing shall be conducted in the same manner as the hearings provided for in section 2029. The commissioner shall, after such hearing, state in writing his findings of fact, his decision, and his order if any; and he shall serve a copy thereof upon all parties of record to the proceeding.

to believe the PPO Option violates the No-Fault Act, and, therefore, the Commissioner abused his authority by failing to institute proceedings.

The Court in *Brandon* found the petitioner's argument unconvincing. It began by reiterating that the Commissioner has statutory discretion to commence or not commence enforcement proceedings under the Act. *See id.* at 263 (*citing* MCL 500.210, 500.1244, 500.2029, 500.2043, 500.2066 and 550.950). As the court explained, "[t]he statutes express this delegation of discretion in terms of the commissioner having 'probable cause' to believe that there was a violation of provisions of the Insurance Code . . . ." *Id.* This broad authority, the court held, gives the Commissioner discretion to decide whether or not to institute case proceedings **even if there is probable cause to believe someone is violating the Insurance Code**. *See id.* at 264. Thus, the court concluded that "[t]he commissioner was authorized by law in his exercise of discretion to determine that there was no violation of [the Insurance Code]. The commissioner is authorized by administrative rule to decline to take action on a petition for a contested case hearing, if he acts in conformity with applicable statutes."[9] *Id.* at 265.

This case is on all fours with *Brandon*. As in that case, MCC/MCS asked the Commissioner to institute contested case proceedings on the ground that Farmers was allegedly violating the No-Fault Act. Exercising his discretion under the Act, the Commissioner denied the request. Under the appropriate standard of review, this is where the case should have ended; the Commissioner had statutory discretion to deny contested case proceedings, and his denial was thus authorized by law.

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[9] In *Northwestern Nat'l*, the Court of Appeals discussed the standard of review in the same context as this case, namely, review of the Insurance Commissioner's decision not to issue a contested case proceeding on request by a petitioner. *See supra* at 486. In discussing the applicable "authorized by law" standard of review for such cases, the court held as follows: "There is apparently much confusion regarding the meaning of this constitutional standard, whether an agency's decision is authorized by law. We agree that, in plain English, authorized by law means allowed, permitted, or empowered by law. . . . [W]e find that [it] is also a reasonable articulation of the constitutional standard [of review] because it **focuses on the agency's power and authority to act rather than on the objective correctness of its decision.**" *Id.* at 488-89 (internal citations omitted; emphasis added).

MCC/MCS have offered no evidence to suggest that the Commissioner exercised his authority in an arbitrary or capricious manner. Instead, their only complaint is that they disagree with the **merits** of the Commissioner's decision not to hold a hearing. But the applicable standard of review does not permit a review of the merits. It is limited to reviewing whether the Commissioner had the authority to act as he did. *See Northwestern Nat'l, supra* at 488-89 (the standard of review "focuses on the agency's power and authority to act rather than on the objective correctness of its decision."). To hold otherwise would give courts the power of *de novo* review, and violate the statutory grant of discretion to the Commissioner to decide whether or not to hold a hearing.

In short, the trial court applied the wrong standard of review. The court should have limited itself to the Commissioner's "power and authority to act." *See id.* at 489. Instead, it evaluated the "objective correctness" of the Commissioner's ruling and held that the Commissioner erred by not instituting contested case proceedings.[10] The trial court's ruling must therefore be reversed, and the Commissioner's denial of the Request and Amended Petition reinstated.

III. EVEN IF THIS COURT UNDERTAKES *DE NOVO* REVIEW, THE COURT OF APPEALS MUST BE REVERSED ON THE MERITS.

Under Michigan law, an agency is entitled to "great deference" in the interpretation of a statute it administers. *Breuhan* v *Plymouth-Canton Community Schools*, 425 Mich 278, 282-83; 389 NW2d 85 (1986). This high degree of deference requires a court to defer to the agency's interpretation unless it is "clearly wrong." *See Michigan Educ Ass'n Political Action Comm* v *Sec'y of State,* 241 Mich App 432, 437; 616 NW2d 234 (2000); *Faircloth* v *Family Indep Agency*, 232 Mich App 391, 406; 591 NW2d 314 (1999). In this case,

[10] On appeal, the Court of Appeals compounded this error by performing its own *de novo* review of the Commissioner's ruling. *See Michigan Chiropractic Council, supra* at 232-247.

as we show below, the Commissioner correctly determined that the PPO Option is consistent with the No-Fault Act. Therefore, even if this Court were to review the matter *de novo*, the Commissioner's interpretation must be upheld.

A. *Tousignant* Holds That a Voluntary System of Managed Care is Consistent With the No-Fault Act.

The Court of Appeals' holding that medical services for automobile injuries under the No-Fault Act cannot be provided through HMOs and PPOs directly conflicts with this Court's prior decision in *Tousignant* v *Allstate Insurance Co*, *supra*. In *Tousignant*, this Court held that the essential feature of a managed care system – a limited choice of physicians and hospitals – is not incompatible with the No-Fault Act.

The injured plaintiff in *Tousignant* had no-fault insurance with the defendant, coordinated with the plaintiff's health insurance provided by her employer through an HMO. *See Tousignant*, *supra* at 304. The plaintiff's medical services for automobile injuries were thus provided directly through the HMO, and the HMO designated the physicians and facilities where covered medical services could be obtained, limiting the plaintiff's freedom of choice. *See id.* at 309. The plaintiff chose to obtain medical services from care providers outside the HMO, and then sought PIP benefits directly from defendant to pay for these non-HMO medical services. *See id.* at 305. The defendant refused payment, *see id.* at 304, and plaintiff brought suit.

On appeal to this Court, the primary issue was the legality of the fundamental feature of managed care systems – a limitation on the insured's choice of physicians and facilities, *i.e.*, is it legal under the Act to exclude some physicians from being able to provide covered medical services to a no-fault insured? This Court held the Act allows a limitation on choice of physicians and facilities if the limitation is the result of the insured's voluntary agreement. *Tousignant*, *supra* at 310.

In reaching this holding, this Court rejected the argument that § 3109a of the Act, which authorizes coordination generally, requires that the health insurer paying for automobile injuries provide the insured with a free choice of physicians and facilities:

> When the "other health coverage" coordinated with no-fault coverage is coverage by a health insurer who is not a health care provider (HMO), and thus the health insurer pays bills rendered by health care providers, the no-fault insured generally has a wide choice of physicians and facilities. Section 3109a, however, does not require that "other health coverage," with which the no-fault insured has chosen to coordinate, provide the no-fault insured with such choice.

Tousignant, supra at 309.

The Supreme Court also rejected the argument that § 3107 of the Act, which states that no-fault insurance must provide PIP benefits for all reasonably necessary medical services, requires the no-fault insured to be given a free choice of physicians and facilities:

> Nor does the legislative policy embodied in § 3107, requiring a no-fault insurer to provide necessary medical expense, require that "other health coverage" under § 3109a provide the no-fault insured with a choice of physician or facility.

Id. at 309-10. The Court concluded that the defendant did not have to provide PIP benefits for the non-HMO medical services because the plaintiff had voluntarily elected to limit her choices of physicians and facilities:

> The no-fault insured may retain a wide choice of physicians and facilities by not coordinating. Where, however, the no-fault insured's employer chooses to provide health insurance, or the no-fault insured chooses to obtain health insurance, from an HMO, and the no-fault insured chooses to coordinate no-fault and health coverages, the no-fault insured has, in effect, thereby agreed to relinquish choice of physician and facility.

Tousignant, supra at 310.

The *Tousignant* decision is dispositive here. MCC/MCS argued in the Court of Appeals that the PPO Option conflicts with § 3107 of the Act. The Court of Appeals agreed, holding that the PPO Option limits an insured's choice of physicians to those who are members

of PPOM, thus undermining the Act's intent to provide a system of unlimited services for no-fault insureds. *See Michigan Chiropractic Council, supra* at 243. But this aspect of the PPO Option does not conflict with the No-Fault Act. As this Court ruled in *Tousignant*, the Act allows insureds to voluntarily limit their choice of physicians, and the non-HMO provider in that case was properly excluded from the insured's no-fault benefits.

In failing to follow *Tousignant*, the Court of Appeals relied heavily on § 3109a of the Act. *See Michigan Chiropractic Council, supra* at 241-43. However, § 3109a of the Act does not create a legal distinction between the coordinated coverage in *Tousignant* and the PPO Option. Section 3109a merely authorizes coordinated coverage. It does not even mention, much less expressly authorize, the use of managed care to provide PIP benefits. In fact, when § 3109a became effective in 1974, managed health care did not exist in Michigan.[11] As *Tousignant* itself illustrates, § 3109a creates, rather than resolves, the issue of managed care's compatibility with the Act. This Court resolved the issue in *Tousignant* by ruling that managed care systems can be the primary providers of medical services for automobile injuries.

Moreover, there is no principled difference between managed care through coordinated coverage and managed care under the PPO Option. With coordinated coverage, no-fault insurance is wrapped around an HMO or PPO. With the PPO Option, no-fault insurance is wrapped around PPOM. With coordinated coverage, the HMO or PPO prescribes the physicians from whom the insured can receive medical services for automobile injuries. With the PPO Option, PPOM prescribes the physicians from whom the insured can receive covered medical services.

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[11] Section 3109a was part of 1974 PA 72. *See Auto Club Ins Ass'n v Frederick and Herrud, Inc*, 145 Mich App 722, 128; 377 NW2d 902 (1985). HMOs came into existence under 1978 PA 368, and PPOs were first authorized by 1984 PA 233.

The only real distinction between the use of managed care with coordinated coverage and the use of managed care under the PPO Option is one of availability. With coordinated coverage, the ability to pay reduced no-fault premiums in exchange for receiving medical services through managed care is available only to Michigan residents having a managed care form of health insurance. With the PPO Option, all Michigan residents have the option of paying reduced premiums in exchange for receiving medical services for automobile injuries through managed care.

In their argument to the Court of Appeals, Appellees attempted to distinguish *Tousignant* by arguing that, where coordinated coverage exists under § 3109a, medical benefits through an HMO or PPO are not technically PIP benefits, citing *Auto Club Ins Assn v New York Life Ins Co*, 440 Mich 126; 485 NW2d 695 (1992). (MCC/MCS Court of Appeals Br at 22-24 (App at 184a-86a).) But this semantic argument misses the point. Section 3107 of the Act entitles a no-fault insured to all reasonably necessary medical services. With coordinated coverage, the insured's general health insurance satisfies this statutory entitlement and, where that insurance is in the form of an HMO or PPO, the insured's statutory entitlement is satisfied through the insured's HMO or PPO — that is, a system of managed care satisfies the insured's statutory right to no-fault benefits. Under these exact circumstances, thousands of Michigan residents presently receive medical services through HMOs and PPOs in full satisfaction of their statutory rights under the No-Fault Act.

Accordingly, if a no-fault insured's statutory rights under § 3107 cannot be satisfied through a managed care system of medical benefits, thousands of no-fault insurance policies presently in place in Michigan are invalid. Fortunately, in *Tousignant*, this Court held that the principal feature of an HMO — an insured's voluntary decision to limit his or her choice

of physicians — does not conflict with the Act. That holding applies here, and the PPO Option does not conflict with any provision of the Act.

B. Even Aside From *Tousignant*, the PPO Option is Clearly Consistent With the No-Fault Act.

In addition to the Court of Appeals' failure to follow *Tousignant*, this Court should reverse the Court of Appeals' decision because the PPO Option is fully consistent with the provisions of the No-Fault Act and furthers the Act's goals of providing needed services at reduced rates.

1. Under settled law, the PPO Option is permissible unless it conflicts with a specific provision of the Act.

As even the Court of Appeals recognized, the No-Fault Act's silence about the permissibility of the PPO Option does not mean the Option is not permitted. *See Michigan Chiropractic Council, supra* at 239. Instead, under this Court's holding in *Cruz v State Farm Mutual Auto Ins Co*, 446 Mich 588; 648 NW 591 (2002), the question is not whether the Act expressly **authorizes** the PPO Option, but whether the Option **conflicts** with any provision of the Act. In *Cruz*, this Court considered whether the No-Fault Act permits examinations under oath (EUOs) in no-fault insurance policies. The Court of Appeals had ruled such EUOs were prohibited because they were not expressly authorized by the Act. This Court held that this was error, and EUOs are only prohibited if the EUO at issue conflicts with a provision of the Act:

> The Court of Appeals . . . found that EUOs were precluded in the automobile no-fault insurance context because they were not mentioned in the act. In our judgment, the Court was in error. EUOs, or other discovery methods that the parties have contracted to use, are only precluded when they clash with the rules the Legislature has established for such mandatory insurance policies.

Id. at 598.

Accordingly, in this case, the issue is not whether the No-Fault Act expressly authorizes the PPO Option. The issue is whether the PPO Option conflicts with any provision of the Act. As we show below, no such conflict exists.

2. The PPO Option is consistent with the mandates of the No-Fault Act.

The Court of Appeals held that managed care is inconsistent with the provisions of § 3107 because managed care, by definition, restricts access to health care providers. *See Michigan Chiropractic Council*, *supra* at 245-47. This holding is erroneous for two reasons.

a. The PPO Option is voluntary.

The Court of Appeals overlooked the one critical fact that harmonizes the PPO Option with the No-Fault Act – the PPO Option is entirely voluntary. No insured is required to purchase the Option and no physician is required to join PPOM. The *Tousignant* decision allowing managed care under the No-Fault Act with coordinated coverage was premised precisely on the existence of voluntary choice. *See supra* at 307-10 ("Coordination of no-fault and health coverages is optional. . . . The no-fault insured may retain a wide choice of physicians and facilities by not coordinating."). Here, the no-fault insured may retain a wide choice of physicians and facilities by not selecting the PPO Option.

The Court of Appeals' ruling also defies common sense. What public policy is promoted by prohibiting insureds, in exchange for reduced no-fault premiums, from agreeing to have all necessary medical services provided by an extensive network of highly qualified physicians? The answer is obvious: none. To the contrary, the PPO Option directly promotes the dual policies of the No-Fault Act by (1) providing all reasonably necessary medical services to insureds while (2) at the same time holding down the costs of medical care and insurance premiums. (*See* pp. 26-27, *infra.*) The Court of Appeals did not – indeed, could not – explain

how the PPO Option could be inconsistent with the No-Fault Act when insureds voluntarily select the Option as a means of reducing the cost of their insurance.

b. The PPO Option meets Farmers' obligations to pay for reasonably necessary medical services.

Section 3107 of the No-Fault Act requires an insurer to pay "all reasonable charges incurred for reasonably necessary products, services and accommodations." MCL 500.3107(1)(a). The PPO Option meets this obligation through PPOM, a network of over 300 hospitals and 30,000 physicians. (Statement of Facts, *supra* at 4.) The network includes, among others, providers of medical, chiropractic, optometric, pediatric, hospital, nursing, x-ray, dental, surgical, ambulance, and prosthetic services. (*See id.*; *see also* Response by Farmers, Sept 25, 2000, Ex 2 (App at 44a).) PPOM provides all reasonably necessary services, and Farmers pays the PPOM provider a reasonable (*i.e.*, contractually established) fee. Insureds electing the PPO Option receive no different scope or quality of care than they would receive from non-PPOM physicians. (*See* Admin Order, Jan 23, 2001, at 6-7 (App at 68a-69a).) The PPO Option, therefore, does not effect Farmers' no-fault obligations to its insureds – that is, to provide all reasonably necessary medical services. Rather, once voluntarily chosen by an insured, the PPO Option simply defines the universe of providers from whom the insured may obtain all reasonably necessary medical treatment.

In short, the PPO Option's voluntary program of managed care is entirely consistent with the principal legislative purposes of the No-Fault Act – namely, **to provide all reasonably necessary medical coverage while at the same time holding down the costs of both medical care and insurance premiums for insureds**. *See McGill v Auto Ass'n of Mich*, 207 Mich App 402, 407-08; 526 NW2d 12 (1994) ("[I]t is to be recalled that the public policy of this state is that 'the existence of no-fault insurance shall not increase the cost of health care.'");

Dean v Ins Ass'n, 139 Mich App 266, 272-274; 362 NW2d 247 (1985) ("[T]he no-fault act was as concerned with the rising cost of health care as it was with providing an efficient system of automobile insurance."); *see also Thomas v State Farm Mut Auto Ins Co*, 159 Mich App 372, 374; 406 NW2d 300 (1987). The Court of Appeals' holding flies in the face of this legislative intent and the rights of Michigan insureds to freely obtain insurance coverage that best suits their personal and financial needs. Opening up insureds' options and concomitantly reducing their premium costs favor the underlying policies of providing all reasonably necessary medical treatment while holding down the costs of both medical care and insurance premiums.

C. The Court of Appeals Erred in Holding That the PPO Option is "Illusory" and Misleading to Insureds.

Two members of the Court of Appeals held that the PPO Option violated the No-Fault Act because it is "illusory" and potentially misleading in its claim of reduced premiums for insureds who select it.[12] *See Michigan Chiropractic Council, supra* at 240-41. The majority cited one, and only one, piece of evidence in support of its holding on this issue – namely, a document attached as Exhibit A to MCC/MCSs' original Request (*see* Farmers Group Insurance Major Automotive Coverages (App at 2a).) The Court quoted from the document to explain the 40% reduction in PIP rates for insureds selecting the Option, and noted that other premium options, including the so-called E7143 and "other insurance credit," are not available if the PPO Option is selected. *See Michigan Chiropractic Council, supra* at 240. The Court then analyzed the issue as follows:

> [U]nder Farmers' policies, if a policyholder elects the PPO option, the policyholder forfeits other PIP premium deductions. This "exchange system" of premium discounts renders illusory the touted reduction in the cost of insurance to policyholders. The question arises whether consumers, who are prone to overlook the detail of their insurance policies, will be lured to accept the PPO option on the basis of

[12] The remaining member of the panel, Judge White, wrote a concurring opinion stating, among other things, that she believed it was unnecessary for the Court to reach this issue.

> the well-publicized forty-percent reduction in their PIP rate, when in fact many will lose significant, and perhaps comparable, premium discounts for the other insurance option or the E-7143, already in place, but which no longer apply. This system certainly has the potential for deception – misleading consumers and the public in general. This potential deception provides further basis for reversing the commissioner's decision pursuant to MCL 500.2029, on the basis of unfair, deceptive, and misleading trade practices.

Id. at 240-41. The Court's holding on this issue is erroneous on several levels.

1. MCC/MCS forfeited the issue by failing to raise it below.

First, the Court of Appeals erred by considering this issue at all. Nowhere in their briefing or argument at the Court of Appeals or the Circuit Court did MCC/MCS contend that the PPO Option is illusory or potentially misleading. (*See generally* MCC/MCS Court of Appeals Brief (App at 156a-205a); Petitioner's Brief on Appeal to the Circuit Court (App at 99a-134a).) "An issue that is not raised before the trial court is not preserved for appeal." *Badiee v Brighton Area Schools, et al*, 265 Mich App 343, 373; 695 NW2d 521, 542 (2005); *accord Burns v City of Detroit*, 253 Mich App 608, 614-15; 660 NW2d 85 (2002) ("This Court has repeatedly declined to consider arguments not presented at a lower level . . . ."). In this case, because MCC/MCS failed to raise the issue in the trial court, the Court of Appeals erred by reaching out and deciding it. *See Badiee, supra* at 373; *Burns, supra* at 615-16.

2. The Court of Appeals erred in making factual findings on an issue for which there is no evidentiary record.

Next, it was inappropriate for the Court of Appeals to make factual findings about the specific effects of the PPO Option on no-fault insureds. The Commissioner did not hold a hearing, and there is no evidentiary record. The Circuit Court did not consider the supposed deceptiveness of the PPO Option, and did not discuss the issue in its opinion. Nevertheless, the Court of Appeals made numerous findings of purported fact: (1) the forty-percent reduction in the PIP rate is "well-publicized"; (2) the forty-percent reduction in the PIP rate is "illusory";

(3) consumers are prone to overlook the details of their insurance policies; (4) consumers will be "lured" to purchase the PPO Option, rather than making a rational decision based on their needs; (4) by offering the PPO Option, Farmers is "misleading consumers and the public in general"; and (5) by offering consumers various options to tailor their no-fault insurance and premiums to fit their needs, Farmers, rather than benefiting consumers, is creating "the potential for deception." *Michigan Chiropractic Council, supra* at 240-41. There was no record from the Commissioner or the trial court on which the Court of Appeals could base such findings. The findings therefore constitute nothing more than speculation.

Furthermore, the No-Fault Act empowers the Commissioner to institute contested case proceedings when there is probable cause to believe an insurer is engaged in deceptive or unfair practices. *See* MCL 500.2029. Only the Commissioner has the power to decide these types of claims, and only when someone has filed a request for contested case proceedings. In this case, no insured has ever claimed that the PPO Option is deceptive or misleading, and the impact of the PPO Option on insureds has never been reviewed by the Commissioner in a contested case. Until this occurs, there is no basis other than speculation for an appellate court to make the type of fact findings made by the Court of Appeals in this case.

3. The Court of Appeals' fact finding was erroneous.

As discussed above, the Court found that the PPO Option was deceptive or illusory because insureds "lured" into selecting the Option would allegedly "forfeit" the benefit of two other premium deductions, the E-7143 and the "other insurance option." But this is finding incorrect for three reasons.

First, the Court of Appeals was confused about the intended function of the E-7143. The E-7143 is a $300 deductible that insureds can select in order to receive a 15 percent

reduction in their PIP rates. There is nothing deceptive about offering an insured a choice between a $300 deductible and a 15 percent premium reduction under a standard no-fault policy, on the one hand, or the PPO Option and a 40 percent premium reduction on the other hand. It simply gives insureds more options to tailor their automobile insurance to fit their needs.

Second, the "other insurance" credit referenced by the Court is nothing more than coordinated coverage under § 3109a of the No-Fault Act. Farmers has always presented the PPO Option as an alternative to coordinated coverage. Rather than being "illusory" or "deceptive," the PPO Option levels the playing field for insureds. In the absence of the PPO Option, only those Michigan insureds who have a managed care system of health insurance can obtain managed care for automobile injuries by coordinating their coverage under § 3109a. The PPO Option provides all Michigan residents with the same opportunity.

Finally, the issue was improperly decided by the Court of Appeals. The Circuit Court's decision was based on the legal issue that was fully briefed and argued by the parties on appeal – whether the PPO Option is facially inconsistent with the No-Fault Act. As Judge White properly recognized in her concurring opinion, the Court of Appeals' decision to affirm the Circuit Court's legal ruling made it unnecessary – and inappropriate – to consider an additional issue that had not been briefed or decided below.[13] *See Michigan Chiropractic Council, supra* at 247.

CONCLUSION

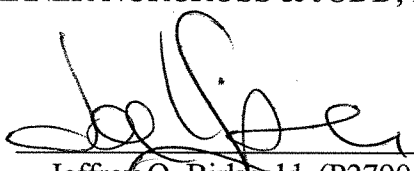
In summary, the Court of Appeals erred on two threshold issues – standing and standard of review – that require immediate reversal and reinstatement of the Commissioner's

[13] In addition to the arguments discussed herein, MCC/MCS argued below that the referendum vote in 1993 PA 143 means that there can be no managed care under the No-Fault Act, so that PIP benefits cannot be paid through HMOs and PPOs. The Court of Appeals correctly found this argument to be groundless. *See Michigan Chiropractic Council, supra* at 246 n 12 ("Because the referendum rejected the act in its entirety, it has little bearing on the disposition of this case.")).

decision not to institute contested case proceedings. Even if this Court looks beyond those issues, however, the Court of Appeals erred on the merits. The court disregarded this Court's holding in *Tousignant*, and erred by ruling on an entirely new issue – the alleged "deceptiveness" of the PPO Option – that had not been raised or addressed below. The PPO Option provides Michigan residents an opportunity to reduce no-fault insurance premiums and fashion their insurance consistent with their needs. The Court of Appeals' ruling forecloses this opportunity and would result in thousands of Michigan insureds being denied the ability to voluntarily select a product that they have found to be in their best interests. Accordingly, Farmers requests that this Court reverse the decision of the Court of Appeals and reinstate the Commissioner's Administrative Orders.

Dated: July 8, 2005

WARNER NORCROSS & JUDD, LLP

By: 

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